

SECTION 8: CLINICAL PLACEMENT GUIDELINES AND PLACEMENT CONTRACTS

AN OVERVIEW OF THE CLINICAL COMPETENCES TRAINEES NEED TO ACQUIRE DURING TRAINING

By design the range and content of clinical placements reflects the criteria set out by the Health and Care Professions Council for registration as a Clinical Psychologist, and by the BPS for Chartering as a Clinical Psychologist. The former are set out in the ‘Statements of Proficiency’ for Clinical Psychologists, and the latter in the accreditation criteria for clinical courses (and are included as appendices to this handbook).

In practice there is considerable overlap between these criteria, and what follows is an outline of the competences trainees need to acquire over the course of training, along with an indication of the client groups with whom they need to work, the clinical contexts in which they see these clients, and the clinical approaches which they need to apply.

As should be clear from the preceding paragraph, it is misleading to think of training pathways as linking only with competences – these are important, but just as critical is the need for trainees to operate in and with a broad range of clinical and organisational contexts and to be acquainted with a variety of psychological approaches.

The diagram below is a schematic representation of the criteria – by no accident it is the basis for the trainee’s ‘cumulative training record, which helps to identify progression through training.

The far left hand column sets out a set of ‘transferable competences’, and the columns to the right the clinical contexts, clinical populations and clinical approaches with whom these competences need to be demonstrated. The ‘transferable skills’ are those identified as a core set of competences for the profession, employed in almost all interventions and contexts. They are described as transferable not only because they are employed so ubiquitously, but also because with repeated application they are employed in an increasingly sophisticated manner. For this reason they are sometimes referred to as “iterative” skills.

The variety of contexts, populations and approaches required of trainees is quite broad, and is intended to develop a capacity to employ a wide repertoire of skills in a range of increasingly complex situations. One hallmark of training should be the acquisition not only of specific skills, but also a capacity to problem-solve and to apply these skills when faced with novel clinical problems, and to both identify and implement appropriate solutions.

The criteria mean that there is no single pathway through training, since the competence standards can be met in a range of clinical contexts. This having been said, there is some consistency in the ‘shape’ of training – for example, trainees need to work with individuals across the lifespan, and this means that they will have placements which give them experience of work with adults with mental health problems, with children and adolescents and with older adults.

Some of the diversity in training pathways is accounted for by the fact that the criteria do not mandate any specific service settings. A good example is the requirement for trainees to work with people with a range of intellectual functioning. This does not mean that all trainees need to work in a service for people with learning disabilities. The criteria identify core *populations* rather than core *placements*; and although in practice these can be coterminous with service settings, this is not always the case. Clearly, work in a child development unit will give trainees experience of work with children with learning

disabilities, even though the service itself is 'labelled' as a child (rather than as a learning disability) service.

PLACEMENT CONTENT AND LEARNING OUTCOMES

Placements offer a great diversity of experience. For this reason the basic template for the placement contract (which sets out the expected trajectory for the placement) restricts itself to signalling the broad areas of placement content. This template can be found in Section 9. Essentially placement content will reflect:

- a) the clinical opportunities available in the clinical service
- b) the supervisor's "generic" capacities and interests
- c) the areas in which the supervisor has specialised knowledge
- c) the trainee's experience to date, as identified by their clinical log
- d) the trainee's training needs, as identified by their reflective practice log and prior supervisor feedback

Specific learning outcomes will reflect the criteria set out in the supervisor feedback form, which specify the domains in which trainees are expected to demonstrate competence. While this structure remains constant across training, the way in which each of these domains are translated into learning outcomes in any one placement needs to reflect the work which is being undertaken. For example, a "capacity to engage clients and to form a working relationship" requires different skills when implemented in an adult psychological therapy unit, contrasted to a children and family unit. In most adult settings this usually involves engaging a single patient, whereas in a children's service it usually involves engagement or liaison with a number of individuals, including the child their parents and families.

Outline of Clinical Psychology training

GENERALISABLE PSYCHOLOGICAL KNOWLEDGE, SKILLS AND ATTITUDES

Knowledge

Able to draw on and apply psychological knowledge

Intervention skills

Able to implement an intervention that includes:

Engagement of relevant individuals

Assessment of problems/issues

A formulation of reasons for problems/ issues

A psychological intervention based on the formulation

An evaluation of the intervention

Able to communicate psychological information to clients and fellow professionals

Able to supervise and train others

Organisational influence and leadership

Able to deploy research skills in clinical and professional contexts

Attitudes and values

Able to work ethically in accordance with professional and organisational values

Capacity for professional autonomy and accountability

AREAS OF APPLICATION

APPLICATION TO A RANGE OF CLIENTS

Work across the lifespan
Children & Adolescents
Adults & Older Adults

Clients with significant levels of challenging behaviour

APPLICATION TO A RANGE OF DIFFERENT PRESENTING PROBLEMS

Working with individuals, families and groups

Acute through to enduring presentations

Clients with impaired neurocognitive functioning

Clients whose disability impacts on communication

Working with psychosocial presentations as well as conditions with a more biological origin

Working with complexity and across co-existing conditions

APPLICATION OF DIFFERENT MODELS

CBT; Psychodynamic; Systemic + other therapies

APPLICATION IN A RANGE OF SERVICE CONTEXTS

Primary care

Secondary care

Specialist settings

Mental Health

Physical Health and Neurorehabilitation

Learning Disabilities

WORKING THROUGH OTHERS

Working with and through teams and other professionals

Working with and through carers

EXPECTATIONS COMMON TO ALL PLACEMENTS

Placement contract

After completing and signing the placement contract with their supervisor, the trainee should submit a PDF to the Electronic Trainee File System (ETFS) by the appropriate deadline (paperwork deadlines located at

http://www.ucl.ac.uk/dclinpsy/clinicalplacement/clinplacement_documents/placement_and_paperwork_dates).

Appended to the contract should be Part C of the trainees' previous EPR form ('Feedback for the attention of the next supervisor'), signed by the new supervisor to show that this feedback has been received.

Note: We encourage trainees to share the whole EPR from their previous placement with their next supervisor, but for the purposes of the placement contract, it is just the Part C section that needs appending.

Expected workload

The type of work carried out in different settings varies, which means that there is no simple way of expressing the amount of work supervisors can expect trainees to undertake. However, as a rule of thumb trainees are expected to undertake at least 8 substantive pieces of clinical work *at any one time*.

Defining a "substantive piece of clinical work" is not straightforward it could be ongoing casework, but also indirect work (such as active participation in a clinical or professional meeting) is also relevant. Supervisors need to use their judgment to decide whether the work is 'substantive'. Sitting in a meeting where there is no expectation of much involvement is very different from acting as a key worker developing a care plan with other members of a MDT. In this sense "substantive" refers in part to the amount of time, as well as the emotional demand made by the work.

The number of cases a trainee sees over the course of a placement is not fixed, and the guideline here is not intended to indicate a maximum number. Trainees should expect to be kept busy, neither overworked nor underworked. Ultimately it is critical that trainees see the number of cases consonant with a good training experience. This means that trainees might see fewer cases in settings where work is very intensive and involves a large amount of collaborative working. Equally, in settings where the work was brief and self-contained, the caseload should be higher.

Observation of trainees, and modelling by supervisors

Observation is a two-way process – trainees observing their supervisor model a skill, and supervisors observing trainees implementing an intervention. These are both potent learning tools – used well they are far and away the most powerful ways of helping trainees to develop. The course expects them to be a standard part of all placements, not only because of their utility, but also because observation in particular is the only way to determine what a trainee *actually* does, as contrasted to what they report. This is critical to the supervisor's ability to determine that a trainee is proficient (and ultimately protecting the standards of the profession).

Most trainees benefit by observing their supervisors, and then moving progressively to more independent work. The speed with which this is done will vary according to the prior experience and (to a degree) the confidence of the trainee. It is often helpful to move through a cycle of: a) the trainee watching the supervisor b) the trainee and supervisor work together jointly c) the supervisor watches the trainee. This pattern is usually easy to implement when conducting assessments.

It is worth noting that observation need not be, and usually isn't, "live". Sessions can be recorded, and trainees are strongly encouraged to purchase a digital recorder. These are unobtrusive and produce a very good sound quality, meaning that there should be no technical bar to implementing recording as a routine part of supervision.

Supervisors should listen to at least some complete sessions, but time constraints may make this difficult to achieve on a regular basis. However, trainees can be asked to select extracts from a session for detailed review (for example, areas where they are puzzled by the way a session developed, or where they would like guidance on the implementation of a specific technique).

Observation should be seen as a routine part of training, despite the fact that being observed can sometimes be experienced as uncomfortable (by trainees and supervisors).

Monitoring therapeutic outcomes

Systematic monitoring of outcomes of interventions should be routine, in line with the principles of clinical governance and of practice-based evidence. Identifying the methods most appropriate to meeting this aim is a matter for supervisors to consider - the aims of services vary, many services have a basic 'minimum data set', and the way in which outcomes are monitored varies with client group.

It is important that monitoring is actively integrated into supervision – in other words, making use of test scores to support thinking about case planning, and using multiple measurement points and using formal procedures to track client progress in a systematic manner. It is also helpful to involve service users in monitoring – for example, by giving them clear feedback on the measures they have completed, making monitoring a collaborative exercise.

Obtaining client feedback is also integral to your work on placement, both to ensure client satisfaction with the service they are receiving as well as for your own professional development. Trainees are required to obtain client feedback using either local service tools (if available) or the UCL client feedback form (also available in an easy read format) This can be found under *Placement Monitoring and Paperwork* (http://www.ucl.ac.uk/dclinpsy/placement_monitoring_and_paperwork). Client feedback should be noted on the clinical log and discussed in supervision. Your MPR visitor will also ask you and your supervisor how you have made use of client feedback to develop your clinical practice.

Working with service users

In addition to direct client feedback, the course encourages trainees to think about ways in which they learn about the perspectives of service-users and carers. As this is harder to achieve when involved in a direct therapeutic relationship the course has specific suggestions about ways in which trainees can consult with service users to achieve this aim (see Section 10).

Research

In at least one placement trainees need to carry out service-related research (see Section 18). There may be further opportunities for service related research relevant to the work of the trainee, and if this is the case it should be discussed as part of placement contracting.

Teaching

Wherever possible trainees should be encouraged to make clinical or academic presentations to colleagues or to undertake formal teaching.

Report writing and correspondence

Entering information into the record is an important professional activity and the contracting process should include discussion of local Trust procedures as well as supervisor's expectations regarding the ways in which trainees document their work. This discussion should encompass clinical notes, clinical

reports or letters to referrers, and also the ways in which supervision notes and recordings made for supervision are maintained.

In order to avoid any misrepresentation trainees should always sign themselves as “Trainee Clinical Psychologist”.

Arrangements for ending placements

- Some months before the end of the placement there should be discussion of expectations regarding arrangements for ending (for example, arrangements for handing over clients, finishing reports (etc)).
- As described in Section 15, there must be a formal End of Placement Review *before the end of the placement* at which the completed Supervisors’ Evaluation form and the Trainee Evaluation of placement form are discussed.

PLACEMENT CONTENT IN SPECIFIC SERVICE SETTINGS

It is helpful to outline the sorts of clinical activities usually associated with work with specific client groups – what follows applies to work in general adult mental health settings, to work with children and young people, people with learning disabilities, work with older adults, and work with people with severe and enduring mental health problems. This is obviously a slightly restricted range of service settings, but much of the guidance may be broadly useful in other areas of clinical activity.

In some areas BPS special interest groups or faculties have published guidance on training content, indicating suggesting the learning outcomes each of these professional groups would expect. These are referenced below.

The following is best seen as guidance – indicative rather than prescriptive, because the actual placement contract supervisors and trainees draw up needs to reflect factors such as the trainee’s prior experiences and training needs, as well as the clinical work actually available.

GUIDANCE FOR THE FIRST PLACEMENT

The first placement for UCL trainees is in a service where they will see adult clients with mental health problems. Usually this is in an Adult Mental Health service, but it could also be located in a health setting, a forensic setting, or an older adult service.

Overall aims

The experiences available will reflect the work offered in the service, but as far as possible the placement should aim:

- to expose trainees to as wide a range of adult mental health conditions as is possible in the context of the service setting
- to familiarise trainees with the clinical skills which are used to manage and treat these conditions
- to expose trainees to the contexts in which treatment takes place
- to familiarise trainees with local organisational issues, including (wherever relevant) issues relating to team working

Induction

Supervisors will need to help trainee’s induction to the NHS and to training, as well as their induction to work in the placement speciality. How much induction is needed will vary; most trainees have some prior experience of work in the NHS or similar settings. It is a good idea to start by finding out what trainees already know, what they feel confident about doing, and what they need to learn. Many trainees feel anxious and deskilled at the start of training, whatever their prior experience. Supervisors need to acknowledge and manage this while striking a balance between being over- and under-protective.

Trainees will need help in adjusting to their new role, and to begin their orientation to the profession and the placement; how much help will depend on their prior experience, competencies, anxieties, special interests, (etc). For this reason the induction needs to be fairly systematic and tailored to the trainee’s needs. Some apparently basic aspects of induction should probably be covered for all trainees, regardless of their experience. This will include a systematic (even if informal) introduction to other members of the unit, and especially to fellow professions and colleagues. They will also need instruction on institutional procedures and policies, ranging from the formal (eg management of health and safety, consent and confidentiality, unit policies and plans), to the “political” (who’s who in the hierarchy and how they should be approached), as well as the informal (where to get coffee and lunch).

Skill development

There are a range of skills which trainees should acquire in this placement, some of which they may have started learning about in previous posts. As a guide, initial skill development probably focuses in the following areas:

a) Basic professional skills

- Basic office procedures (such as administering referrals, arranging appointments and responding to cancellations).
- Basic professional and management skills related to client contact (e.g. understanding and respecting confidentiality)
- Working with diversity - building confidence in work with individuals of varying demographic backgrounds, ages and ethnicity)

b) Specific assessment and formulation skills

- Techniques and procedures relevant to structured assessment and evaluation, such as relevant standardised assessment procedures (eg Beck Depression Inventory etc) or psychometric techniques
- Interviewing and assessment skills (eg taking a history, identifying significant clinical issues, developing and testing-out hypotheses)
- Formulation skills (eg developing the capacity to formulate and to present formulations in form and language appropriate to clients, colleagues and to referrers).

Unless the service *never* receives appropriate referrals, a good target would be for trainees to undertake at least two formal psychometric assessments, and to communicate test findings to client(s) and to colleagues.

c) Specific intervention skills

- Engagement skills (establishing rapport, , engaging the client and building and maintaining a therapeutic alliance)
- Generic therapeutic skills, such as listening skills or expressing empathy in listening
- Learning to use a range of clinical techniques and approaches, applied in the context of a thorough assessment and formulation

The type of intervention trainees apply should reflect the evidence-base, but as noted below it is also important that supervisors focus their supervision on models with which they are familiar.

d) Learning from experience

- Developing a capacity to reflect on (and hence learn from) experience
- Beginning to integrate academic knowledge and clinical experience

Range of clinical cases

Direct clinical work is expected to form the core of this placement, so that trainees can begin to acquire assessment and intervention skills. Though trainees should gain a range of experience, no one placement can be expected to provide comprehensive coverage. Supervisors should not feel burdened by trying to find types of cases which they do not normally treat themselves. However, when selecting cases, it may be useful to consider the categories below and to aim for variety:

- Cases from across the age range (while remembering that life stages are more important than chronological age).

- Problems of varying duration and severity - for example acute life crises or symptoms of recent onset through to longstanding psychological problems; milder presentations through to severe problems (eg personality disorder, psychotic presentations).
- A range of presenting problems - the most important factor is to ensure that problems are not drawn from just one diagnostic category or problem area.
- Cases which reflect the usual diversity of local populations, in terms of gender, class and ethnic and cultural background
- If possible, it is helpful if trainees gain experience with more than one different level of intervention (e.g.: individual, couple, family, work with carers/staff)
- If possible trainees should have experience of indirect working – for example with professional carers (e.g. developing an intervention programme on a ward), or with carers (e.g. helping families to think about coping with a relative’s behaviour).
- As many cases as possible should be seen by the trainee from assessment through to termination, so that there is experience of the “cycle” of an intervention.

Range of clinical approaches

- If possible trainees should be exposed to more than one therapeutic approach. However whether this is feasible depends on the availability of appropriately skilled supervision, and this will vary - some supervisors are confident in applying more than one approach, others less so. While it may not always be practical or appropriate to include direct experience of more than one orientation, there may be opportunities for indirect learning (for example, through discussion and observation of other members of staff).
- It is better for a trainee to learn about one approach thoroughly than for supervisors to attempt to cover approaches with which they are unfamiliar. Whatever experience is on offer, there should always be an openness to discussion of alternative approaches to treatment.

Working with other professionals

In most settings trainees will need to be familiar with the procedures used to co-ordinate client care across professional groups and potentially across agencies, and learn how to operate effectively with these systems. They should learn about the organisational processes that operate in clinical meetings and use this knowledge to make effective contributions.

Wherever possible trainees should gain experience of the work of teams, and of the ways in which psychologists work in teams. This should include both intra-professional meetings (such as psychology meetings) as well as inter-professional.

STRUCTURING ONE-YEAR PLACEMENTS IN THE FIRST YEAR

Almost all our first-year placements now last for one year. This has huge advantages for trainees (they can get settled-in to the work) and for supervisors and services (trainees can undertake much more meaningful pieces of clinical work, and supervisors recoup the hard work that goes into the induction period). If you are offering a one-year placement it is worth giving some thought to the way in which it is structured. These comments are intended as a supplement to the general placement guidelines.

The overall ‘shape’ of the placement should be planned from the outset, in order to make sure that full advantage is taken of the placement duration.

Settings where the focus will be on AMH for the whole year

Care should be taken to plan the placement in a way which ensures that trainees gain a diverse set of experiences. For example:

- work in more than one setting – there is no one prescription for this, but a mix of settings (eg ideally a mix which could include outpatient, inpatient, CMHT work)
- different approaches to intervention
- diversity in terms of complexity and challenge of presentation

Settings where the placement is shared with other services (such as health, older adult or substance abuse): Both trainees and supervisors need to be clear from the outset about the way in which placement experiences will be sequenced. For example, will there be two six-month blocks, or will the trainee be exposed to different settings in parallel? Who is supervising which aspect of the placement? Who is coordinating the experiences?

When placements are undertaken as two discrete six-month blocks, it is worth remembering that planning and induction for the second block can be carried out before the first placement ends. For example, in the last month of the first block trainees could spend half a day a week in the new setting. Equally, it may be sensible (both clinically and from the perspective of training) to plan for some carry-over of clinical work from the first placement into the second, in order to give the trainee a proper experience of longer-term work. All of this needs careful planning from the outset if it is to work.

Responsibility for liaison among supervisors: If trainees have more than one supervisor over the year, one supervisor should act as the coordinator of training, ensuring that overall professional development is being monitored, making sure that the components of training fit together, and being available to act as a link to the course for relevant personnel matters.

If there is a clear transition between AMH and other services there should be a formal "handover" meeting of the supervisors and trainee.

GUIDANCE FOR WORK WITH CHILDREN AND ADOLESCENTS

Overview

There is considerable variability in the pattern of services for children and adolescents, and hence in the nature of the experience which can be offered to trainees. Rather than specifying the essential components of a child placement, the outline contract which follows indicates the broad areas to which trainees should have some exposure. This allows the supervisor and trainee to specify the precise types of experience available in each unit.

In general, trainees need to be familiar with normal child development in order to understand the clinical presentations with which they will work. Ideally trainees without prior experience of work with children should have some contact with normal children as part of their induction.

All trainees would be expected to have exposure to direct work with children, work with families and parents, and liaison with other professionals and agencies (schools, Social Services, Paediatricians etc).

Induction and orientation

The aim should be to establish the trainee's familiarity with this area of work e.g.:

- their knowledge of 'normal' child development
- their prior experience with children (both professional and informal)
- their level of confidence in relating to children.

Where trainees are very inexperienced in this area, or lacking confidence, some contact with 'normal' children may help them to establish a knowledge base and increase their confidence – for example, spending time in a nursery, observing health visitors, observations. Encouraging trainees them to play or interact with the babies or children of friends or relatives may also be helpful, though this should be structured and discussed in supervision.

There should be explicit and careful discussion of local child protection procedures, and an understanding of the roles of the clinical psychologist and the trainee in this area.

Direct case experience

Casework, undertaken independently or with the supervisor should include exposure to work not only with children, but where relevant with their parents and families

In planning clinical experience (but obviously dependent on the service setting) supervisors should try to achieve as broad a range of experiences as possible:

Ideally trainees should undertake:

- a range of assessment methods (including psychometric assessment) and observations across different contexts
- a range of treatment approaches
- a range of presenting problems
- as wide a range of ages as possible (0-5; 5-11; adolescents)

Trainees should be exposed to clients from as many differing social settings, social classes and ethnicity as is feasible.

DCP Faculty guidance

The Faculty for children and young people have published a good practice guideline which identifies good practice in relation to Clinical Psychology training. This expands on much of what is written above, and can be found as Section 8 Appendix 2 of this handbook or downloaded from the BPS website.

GUIDANCE FOR WORK WITH PEOPLE WITH LEARNING DISABILITIES

Overview

By working in a learning difficulties service the trainee should develop a good understanding of the role of the clinical psychologist. This is best done through:

- direct and indirect working, giving experience of assessment and intervention procedures and techniques with people with learning difficulties - ideally both adults and children
- work in a variety of settings
- work with other professionals

Induction and orientation

Trainees need to acquire knowledge (through reading, discussion and structured observation) of historical and current practice and thinking about psychology services for people with learning difficulties. This includes consideration of the values that underpin services, service organisation and systems.

Direct Client work

Assessment and investigation: It is essential that the trainee gain experience of the application of a range of methods of assessment and clinical investigation. Some examples include: semi-structured interviewing, direct observation, psychometric assessment, functional analysis, risk assessment, etc. Experience of working with an interpreter is also desirable.

Intervention: It is essential that the trainee gain experience of a range of methods of intervention, e.g. psychotherapeutic, behavioural, cognitive behavioural and counselling interventions. One piece of direct work with a client through the three phases of assessment, intervention and follow up is a suggested requirement.

Care planning systems: It is essential that the trainee gain experience of care planning systems, either directly or through observation, e.g., contributing to community care assessments, the care programming approach, etc.

Range of clients: It is essential that the trainee gain some experience of the work of a clinical psychologist with a wide range of clients of different abilities, age, gender, race and culture. Trainees need to gain experience of clients who have challenging needs; autism; dual diagnosis.

Group work: It is desirable that trainees gain experience of group work with people with learning difficulties (e.g. running an assertiveness group, or a bereavement group or a transition group).

Indirect work

Work with family carers: Where possible trainee should gain experience of work with the family or family member of a person with learning difficulties.

Work with 'professional' carers: Trainees should work with a paid carer/staff team through the three phases of assessment, intervention and wherever possible, follow-up.

Work with MDTs, other professionals and other agencies: Trainees should gain experience of work with other professionals from a range of services/agencies.

Work within systems and organisations

Knowledge of service organisation: Trainees need to gain – and apply - knowledge of the role of the psychologist at the level of the service organisation eg: local service development, implementing community care legislation.

Range of settings: Trainees should have the opportunity to experience work in a range of settings (e.g. residential, educational, day-care settings, hospital, home, etc). They should also gain an understanding of service networks and their importance.

DCP Faculty guidance

The Faculty for learning disabilities have published a good practice guideline which identifies good practice in relation to Clinical Psychology training. This expands on much of what is written above, and can be found as Section 8 Appendix 3 of this handbook or downloaded from the BPS website.

GUIDANCE FOR WORK WITH OLDER PEOPLE

Overview

Since no two placements with older people will offer the same clinical experience it follows that placements will vary with the setting, the supervisor's areas of expertise and the trainee's experience and needs. However, some of the basic areas of experience that will usually be met by this placement include:

- assessment and interventions of both functional and organic problems
- direct work with elderly people and indirect work with families and other carers
- experience which helps the trainee understand the organisational and legislative context of services for older adults
- experience of liaison with statutory and non-statutory agencies

Induction and orientation

Trainees need to acquire knowledge (through reading, discussion and structured observation) of historical and current practice and thinking about psychology services for older people. This includes consideration of the values that underpin services, service organisation and systems.

Direct case experience

Trainees should gain experience in the following areas:

- a) Clients presenting with functional disorders. Ideally trainees should see a range of patients (both male and female), ranging in age from the elderly (65 - 74) to the very elderly (85+), presenting with a wide variety of functional disorders, including depression, anxiety and inappropriate behaviour.
- b) Clients with dementia. It is desirable that they see a variety of patients ranging from those with mild memory impairment through those with a moderate focal impairment, (such as dysphasia or visual agnosia) to those with a global cognitive impairment.
- c) Patients with adjustment problems consequent on the psychological and physical events common in this age group, such as retirement, stroke or disability.

Service context

Trainees work should take place in a variety of settings, for example, the patient's own home, day centres, long stay hospital, or residential homes.

Indirect work

Trainees should gain experience of indirect work with and through staff, families and other carers. It is desirable that indirect work with staff takes place in more than one setting and with staff from different disciplines (e.g. nurses, medical staff, social workers, health visitors, or occupational therapists).

Assessment skills

Developing clinical interviewing skills and building rapport with older people requires basic knowledge of the range of physical problems older people commonly have to contend with (for example, heart disease, respiratory problems, arthritis and other mobility difficulties), as well as impairments of sight and hearing. In addition, it requires an awareness of social problems such as poor housing, financial constraints and social isolation.

The person's previous life experience, experience of loss and former coping strategies, both cognitive and behavioural, must also be built into the assessment procedure.

In order to conduct effective psychological care the trainee should be able to conduct a holistic assessment of the person's current situation (including physical, environmental, social and psychological domains) and be aware of the potential interaction between these different variables.

Trainees need to acquire knowledge in and experience of using a range of formal assessment procedures specifically designed for the elderly including cognitive and behaviour analysis.

Intervention skills

Trainees should have an appreciation of the wide range of psychological interventions and the ways that these are adapted for work with older people (e.g. therapies, interviewing and assessment techniques). They should also gain knowledge of psychological therapies designed for use with older people.

If possible trainees should have experience of designing individual care plans with realistic but objective goals and planned interventions. This experience can be gained either in direct work with the patient or in indirect work with staff, relatives or other carers.

Again if possible, trainees should gain experience of group interventions designed for older people and/or their carers (e.g. reality orientation, reminiscence therapy, task-orientated staff group, staff support group, relatives support group).

Experience of the organisation

Trainees should gain an understanding of the potential contribution that Clinical Psychologists can make within the wider service provision of both the Health Service and the Social Services, including their input to service planning.

Trainees should gain experience of working alongside and together with other professionals and develop an appreciation of their responsibilities, problems and concerns. If possible they should also gain experience of provision for older people based in the voluntary sector.

DCP Faculty guidance

The Faculty for psychologists working with older people have published a good practice guideline which identifies good practice in relation to Clinical Psychology training. This expands on much of what is written above, and can be found as Section 8 Appendix 4 f this handbook, or can be downloaded from the PSIGE website: <http://www.psige.org/publications.php>

OLDER PEOPLE: GUIDANCE ON GAINING EXPERIENCE, AND FOR MINIMUM LEVELS OF EXPERIENCE

Background

BPS accreditation criteria specify that trainees should gain experience with individuals across the lifespan. This means that at some point in their training they need to have undertaken worked with older adults. How they gain this experience varies from trainee to trainee – there is no requirement for trainees to undertake a complete placement in work with Older Adults. Though the majority of trainees do undertake such placements, they can gain also experience of work with older adults in the context of other service-settings. This Section describes the ways in which this experience can be gained, and the criteria for minimum experience.

What defines clients as "Older Adults"?

Defining ‘older adults’ is contentious, both for service users and for services themselves. Within the NHS the age cut-off for services for older people varies - in some settings it is 65, in others 70, and in some locations AMH services see individuals of all ages unless there is a clear indication that they need the specialist input of an older adult service.

For good reason, accreditation criteria do not define older adults by age, though there is a common misconception that it is defined as 65+. It may be better to think of life-stage rather than age, though age cannot be disregarded entirely - a good rule of thumb might be 60+.

In terms of trainees’ learning, type of presentation will often be as important as age. A 65 year old presenting with a self-contained specific phobia treated as an out-patient might not give trainees much insight into problems confronting individuals in later life. In contrast, there could be much to learn about issues confronting individuals in later life from contact with a socially isolated 62 year old who has recently lost his/her partner and been retired from his/ her job. However, there are limits to how far the issue of age can be ignored - for example, a 48 year old with dementia would not be an appropriate case - the issues raised would be different from a later-onset presentation.

Gaining experience in placements with older adult service contexts

There are often opportunities to work with older adults work in a range of speciality settings, not only in Adult Mental Health services, but also other areas – for example, forensic settings, in work with people with serious and enduring mental health problems, health placements, or within neuropsychological units. As trainees are expected to acquire a ‘portfolio’ of experience across all three years of training, experience of work with older people can be gained in more than one placement.

MINIMUM KNOWLEDGE AND EXPERIENCE OF WORK WITH OLDER PEOPLE

Assessment and awareness of neurological and organic presentations

It is desirable that trainees should have direct experience of assessing individuals whose management requires understanding and (where relevant) management of neurological and/or organic problems. Relevant presentations would be individuals with:

- dementia
- the sequelae of stroke
- adverse reactions to medications
- sleep problems

While psychometric assessment will be important in formulating such presentations, broader assessment approaches will usually be needed if trainees are to develop a holistic formulation and management plan. There will usually be some contact with and support for the client and their carers (both family and where relevant professional carers), along with contact with members of other disciplines in order to develop care plans.

Functional presentations

As noted above, chronological age can be misleading as a way of thinking about a client's needs, and it is important that trainees learn how to develop a frame of reference that enables them to formulate the pertinence of life-stage and development to a clinical presentation. From this perspective there is no formula for indicating which cases will be most relevant to learning, though clearly clients in late old age are more likely to present with issues in which the psychological and physical consequences of ageing are more prominent.

Indirect/organisational work/service knowledge

Ideally trainees should have some contact with carers of older people - this would usually be gained in connection with the clinical work outlined above (eg gathering information as part of a functional assessment; implementing an intervention or giving feedback about the outcome of an intervention or assessment).

It may be possible for trainees to gain experience of service and organisational issues relating to older people (for example, through visits to local services and discussion with local psychologists working in these services).

Number of cases

Trainees will be expected to see at least four cases of individuals in later life.

- presentations can be either functional or organic (as described above)
- the client's presentation and circumstances should be representative of problems faced by individuals in later life
- the trainee's clinical involvement should be substantive (usually an assessment followed by direct intervention, or by indirect intervention (where the trainee is involved in making clear recommendations for further intervention through the agency of other individuals which are themselves monitored for efficacy)
- cases can be seen in any clinical setting

GUIDANCE FOR WORK WITH INDIVIDUALS WITH SEVERE AND ENDURING MENTAL HEALTH PROBLEMS

Overview

Placements should be designed to equip the trainee with sufficient knowledge of the client group and of the techniques and competencies of the practice of clinical psychology in settings for the assessment, treatment and management of people with long term, serious mental health problems.

Not all placements will meet these aims in the same way, as there is wide variability in the pattern of services. Some offer trainees the opportunity to carry a considerable personal caseload, others are characterised by more indirect, organisational work, or research, or work with and through non-psychologists. Trainees' experience varies widely as well: some will come on placement already familiar with individuals with serious mental health problems; others will never have met people who hear voices, or will have no experience of work in an inpatient setting. Some attention to identifying the trainee's and the supervisor's 'starting points' in relation to these issues will probably pay dividends later on.

It will be worth talking with the trainee to see what clinical competencies they have acquired in prior placements or positions. Assessment and intervention skills acquired in adult mental health, learning disabilities and work in the care of older people, etc, will obviously be very relevant to work in psychiatric rehabilitation.

Induction

It would be helpful to find out what knowledge the trainee has about this area of work at the outset of the placement. This will vary according to the timing of the placement in relation to academic teaching, and the trainee's previous experience and reading. Essential basic knowledge (much of which is covered in academic teaching) probably includes:

- The concept of schizophrenia, bipolar disorder and the major personality disorders.
- History of services for long term care (institutional vs. community care).
Psychological models/concepts (needs, skills, quality of life, social support, values based, recovery)
- Assessment (broad based functional plus traditional psychiatric and psychological).
- Treatment approaches (individual, group, care management and care planning).
- The organisation and range of services (early intervention, crisis resolution and assertive outreach services, as well as more traditional community and inpatient psychosocial rehabilitation services) as well as understanding of quality issues, support of carers and service development
- Relevant research strategies (e.g. for audit and small-scale service evaluation or quality improvement projects)

Trainees acquire knowledge in different ways: through structured personal experience, reading, observation, feedback and discussion in supervision. It is also the case that not all this knowledge can be acquired at once – and much of it depends on matching experience to any reading.

Areas of clinical experience

- Interviewing (clients with communication and attention difficulties)
- Formulation (incorporating information from a multiple theoretical base)
- Realistic goal setting (balancing prognostic factors and evidence of effectiveness of intervention strategies)
- Design of appropriate interventions (to include direct, indirect and organisational interventions)
- Care management (negotiating targets with client and relevant others)

- Work within the organisation (applying psychological models to the organisation, communicating effectively with other staff, participation at all relevant levels of the organisation)
- Evaluation methods including client self-assessment

Direct and Indirect Experience

Direct individual work requires an understanding of the personal and social/economic impacts of psychosis and severe mental health presentations, as well as strategies for and techniques of psychological and psychosocial interventions. Indirect work through multidisciplinary teams is especially important in psychosocial rehabilitation and a positive experience of teams should be an important feature of a trainee's placement. This experience would include:

- learning about the roles and responsibilities of the range of professional and non-professional colleagues in both statutory and non-statutory services
- becoming aware of the issues of communication and liaison involved in care management
- opportunities to work alongside colleagues from other disciplines and agencies
- presenting clinical or theoretical material to multidisciplinary or multi-agency team meetings